

Patient Interview Form

Patient Information

First Name: _____ Last Name: _____
MRN: _____ Date Of Birth: _____
Age: _____

Race

- White/Caucasian Black or African American Asian Hispanic or Latino American Indian or Alaska Native
 Native Hawaiian or Other Pacific Islander Mixed Other Unknown Patient declines to provide information
 Prohibited by state law

Ethnicity

- Hispanic or Latino Not Hispanic or Latino Patient declines to provide information Prohibited by state law

Preferred Language

- English Spanish Other: _____

Contact Preference

- Letter Telephone call Other: _____

Allergies

- Patient has no known allergies Patient has no known drug allergies
 Aspirin Codeine Demerol Fentanyl Flagyl
 Iodine IV Dye Levaquin/Cipro Morphine Penicillins
 Sulfa Versed Latex Eggs Shellfish
 Nuts Other Manifestations/Reactions: _____

Immunizations

- None
 Hepatitis B Hepatitis A Influenza Pneumovax Tetanus
When: _____ When: _____ When: _____ When: _____ When: _____
 Varicella/VZV
When: _____

Current Medications

- None
- | Name | Dose | How taken? |
|-------|-------|------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Pharmacy

Name: _____

Past Medical History

None

Cancers:

<input type="radio"/> Colon	<input type="radio"/> Esophageal	<input type="radio"/> Liver	<input type="radio"/> Small Intestine
<input type="radio"/> Stomach	<input type="radio"/> Kidney	<input type="radio"/> Pancreas	<input type="radio"/> Bladder
<input type="radio"/> Lymphoma	<input type="radio"/> Lung	<input type="radio"/> Skin	<input type="radio"/> Prostate
<input type="radio"/> Breast	<input type="radio"/> Cervical	<input type="radio"/> Ovarian	<input type="radio"/> Uterine
<input type="radio"/> Other:			

Liver:

<input type="radio"/> Fatty Liver	<input type="radio"/> H. Pylori	<input type="radio"/> Hepatitis B, Active	<input type="radio"/> Hepatitis C, Active
<input type="radio"/> Hepatitis, Autoimmune	<input type="radio"/> Other:		

Digestive:

<input type="radio"/> Acid Reflux	<input type="radio"/> Barrett's Esophagus	<input type="radio"/> Celiac Sprue	<input type="radio"/> Cirrhosis of Liver
<input type="radio"/> Colon Polyps	<input type="radio"/> Crohn's Disease	<input type="radio"/> Diverticulitis (Infected)	<input type="radio"/> Diverticulosis
<input type="radio"/> Irritable Bowel Syndrome	<input type="radio"/> Pancreatitis	<input type="radio"/> Ulcer	<input type="radio"/> Ulcerative Colitis
<input type="radio"/> Other:			

Miscellaneous:

<input type="radio"/> Anxiety/Panic Attacks	<input type="radio"/> Arthritis	<input type="radio"/> Asthma	<input type="radio"/> Atrial Fibrillation
<input type="radio"/> Congestive Heart Failure	<input type="radio"/> Carotid Artery Disease	<input type="radio"/> Depression	<input type="radio"/> Diabetes
<input type="radio"/> Emphysema	<input type="radio"/> Endometriosis	<input type="radio"/> Fibromyalgia	<input type="radio"/> Glaucoma
<input type="radio"/> Heart Attack	<input type="radio"/> High Blood Pressure	<input type="radio"/> High Cholesterol	<input type="radio"/> HIV
<input type="radio"/> Kidney Disease	<input type="radio"/> Lupus	<input type="radio"/> Osteopenia	<input type="radio"/> Osteoporosis
<input type="radio"/> Seizure Disorder	<input type="radio"/> Sleep apnea	<input type="radio"/> Stroke/TIA	<input type="radio"/> Thyroid, Overactive
<input type="radio"/> Thyroid, Underactive	<input type="radio"/> Other:		

Vitamins, Herbal and Dietary Supplements

Please list vitamins: _____

Please list herbal supplements: _____

Please list dietary supplements: _____

Previous Gastroenterology Procedures

None

<input type="radio"/> Colonoscopy	<input type="radio"/> EGD/Upper Endoscopy	<input type="radio"/> ERCP	<input type="radio"/> Endoscopic Ultrasound/EUS	<input type="radio"/> Small Bowel Capsule
<input type="radio"/> Liver Biopsy	<input type="radio"/> Other:			

Surgical Procedures

None

<input type="radio"/> Appendectomy	<input type="radio"/> C-Section	<input type="radio"/> Cataract surgery	<input type="radio"/> Colon Resection	<input type="radio"/> Coronary artery bypass
<input type="radio"/> Coronary/Stent	<input type="radio"/> Defibrillator	<input type="radio"/> Gallbladder removed	<input type="radio"/> Gastric By-Pass	<input type="radio"/> Heart Valve Replacement/Repair
<input type="radio"/> Hemorrhoidectomy	<input type="radio"/> Hiatal Hernia Surgery (for reflux)	<input type="radio"/> Hysterectomy, Partial (ovaries intact)	<input type="radio"/> Hysterectomy, Total (ovaries removed)	<input type="radio"/> Inguinal Hernia Surgery (groin)
<input type="radio"/> Joint Surgery / Replacement	<input type="radio"/> Lap Band	<input type="radio"/> Liver Transplant	<input type="radio"/> Mastectomy	<input type="radio"/> Pacemaker
<input type="radio"/> Prostatectomy	<input type="radio"/> Tonsillectomy	<input type="radio"/> Tubal Ligation	<input type="radio"/> Ulcer Surgery	<input type="radio"/> Umbilical Hernia Surgery (belly-button)
<input type="radio"/> Other:	<input type="radio"/> Other:			

